Initial Approval: July 10, 2013
Revised Date: October 8, 2014
July 9, 2014

CRITERIA FOR PRIOR AUTHORIZATION

Topical & Buccal Androgen Hormone Agents

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug(s) require prior authorization:
Testosterone Powder for Compounding
Testosterone Transdermal (Androderm®)
Testosterone Topical Gel (AndroGel®, Fortesta®, Testim®, Vogelxo®)
Testosterone Topical Solution (Axiron®)
Testosterone Buccal (Striant®)
Testosterone Nasal Gel (Natesto®)

CRITERIA FOR PRIOR AUTHORIZATION: (must meet all of the following)

- Patient has one of the following diagnoses:
  - Primary hypogonadism (congenital or acquired)
    - Primary hypogonadism (testicular failure) due to conditions such as (but not limited to) cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals
  - Hypogonadotropic hypogonadism (congenital or acquired)
    - Hypogonadotropic hypogonadism due to (but not limited to) idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation
- Patient must be a male
- Patient must have serum testosterone < 300 ng/dL

PATIENT MUST MEET INITIAL CRITERIA FOR RENEWALS

LENGTH OF APPROVAL 12 months